UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

INNOHEP (tinzaparin sodium,porcine)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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AUTHORIZATION OBTAINED WITH A TELEPHONE CALL OR LETTER OF MEDICAL NECESSITY

CRITERIA:

- Documented diagnosis of a DVT/PE
- Treatment in conjunction with coumadin regulation and treatment. (Maximum of 10 days, 20 units)

RE-AUTHORIZATION:

INR levels, or request to the Drug Utilization Review Board.